

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06808

6833

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. VA. b. COUNTY GREENBRIAR	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) BELFOREST HILL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RENICKS VALLEY	
c. LENGTH OF STAY IN 1b 11 mos		d. STREET ADDRESS RURAL DELIVERY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CHESTNUT HILL RD, RD #1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RESSIE PEARL BLAKE		4. DATE OF DEATH JUNE 14 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 9, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY SAME	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIS CUTLIP		14. MOTHER'S MAIDEN NAME EMMA BROWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT RUTH BROWN, FOREST HILL, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA - ORTHOSTATIC PNEUMONIA 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA UTERUS WITH GENERALIZED METASTASES DUE TO (c) OVER 1YR		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Hour a. ft. — p. m. — 19 —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) — (County) — (State) —
21. I certify that I attended the deceased from JUNE 14, 19 59 to JUNE 14, 19 59 that I last saw the deceased alive on JUNE 14, 19 59 , and that death occurred at 1:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 307 HICKORY DATE SIGNED JUNE 14, 19 59			
ACTUAL SIGNATURE Philip W. Heuman M.D.		PHYSICIAN'S NAME (Type) PHILIP W. HEUMAN, M.D. BEL AIR, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 17, 19 59	22c. NAME OF CEMETERY OR CREMATORY End of the Trail	22d. LOCATION (City, town, or county) (State) E. Pennello W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. C. Baker ADDRESS Benson Md		24a. REC'D BY REGISTRAR JUN 18 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

CERTIFICATE OF DEATH

883

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>1. NAME OF DECEASED JAMES EARL RAY</p>		<p>2. SEX Male</p>	
<p>3. AGE 35</p>		<p>4. DATE OF BIRTH April 14, 1928</p>	
<p>5. PLACE OF BIRTH Jackson, Mississippi</p>		<p>6. OCCUPATION Attorney</p>	
<p>7. MARITAL STATUS Single</p>		<p>8. DATE OF DEATH April 4, 1968</p>	
<p>9. PLACE OF DEATH Memphis, Tennessee</p>		<p>10. CAUSE OF DEATH Heart Disease</p>	
<p>11. MANNER OF DEATH Natural</p>		<p>12. SIGNATURE OF PHYSICIAN [Signature]</p>	
<p>13. SIGNATURE OF REGISTRAR [Signature]</p>		<p>14. SIGNATURE OF DECEASED [Signature]</p>	
<p>15. SIGNATURE OF WITNESS [Signature]</p>		<p>16. SIGNATURE OF DECEASED [Signature]</p>	
<p>17. SIGNATURE OF DECEASED [Signature]</p>		<p>18. SIGNATURE OF DECEASED [Signature]</p>	
<p>19. SIGNATURE OF DECEASED [Signature]</p>		<p>20. SIGNATURE OF DECEASED [Signature]</p>	
<p>21. SIGNATURE OF DECEASED [Signature]</p>		<p>22. SIGNATURE OF DECEASED [Signature]</p>	
<p>23. SIGNATURE OF DECEASED [Signature]</p>		<p>24. SIGNATURE OF DECEASED [Signature]</p>	
<p>25. SIGNATURE OF DECEASED [Signature]</p>		<p>26. SIGNATURE OF DECEASED [Signature]</p>	
<p>27. SIGNATURE OF DECEASED [Signature]</p>		<p>28. SIGNATURE OF DECEASED [Signature]</p>	
<p>29. SIGNATURE OF DECEASED [Signature]</p>		<p>30. SIGNATURE OF DECEASED [Signature]</p>	
<p>31. SIGNATURE OF DECEASED [Signature]</p>		<p>32. SIGNATURE OF DECEASED [Signature]</p>	
<p>33. SIGNATURE OF DECEASED [Signature]</p>		<p>34. SIGNATURE OF DECEASED [Signature]</p>	
<p>35. SIGNATURE OF DECEASED [Signature]</p>		<p>36. SIGNATURE OF DECEASED [Signature]</p>	
<p>37. SIGNATURE OF DECEASED [Signature]</p>		<p>38. SIGNATURE OF DECEASED [Signature]</p>	
<p>39. SIGNATURE OF DECEASED [Signature]</p>		<p>40. SIGNATURE OF DECEASED [Signature]</p>	
<p>41. SIGNATURE OF DECEASED [Signature]</p>		<p>42. SIGNATURE OF DECEASED [Signature]</p>	
<p>43. SIGNATURE OF DECEASED [Signature]</p>		<p>44. SIGNATURE OF DECEASED [Signature]</p>	
<p>45. SIGNATURE OF DECEASED [Signature]</p>		<p>46. SIGNATURE OF DECEASED [Signature]</p>	
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<p>49. SIGNATURE OF DECEASED [Signature]</p>		<p>50. SIGNATURE OF DECEASED [Signature]</p>	
<p>51. SIGNATURE OF DECEASED [Signature]</p>		<p>52. SIGNATURE OF DECEASED [Signature]</p>	
<p>53. SIGNATURE OF DECEASED [Signature]</p>		<p>54. SIGNATURE OF DECEASED [Signature]</p>	
<p>55. SIGNATURE OF DECEASED [Signature]</p>		<p>56. SIGNATURE OF DECEASED [Signature]</p>	
<p>57. SIGNATURE OF DECEASED [Signature]</p>		<p>58. SIGNATURE OF DECEASED [Signature]</p>	
<p>59. SIGNATURE OF DECEASED [Signature]</p>		<p>60. SIGNATURE OF DECEASED [Signature]</p>	
<p>61. SIGNATURE OF DECEASED [Signature]</p>		<p>62. SIGNATURE OF DECEASED [Signature]</p>	
<p>63. SIGNATURE OF DECEASED [Signature]</p>		<p>64. SIGNATURE OF DECEASED [Signature]</p>	
<p>65. SIGNATURE OF DECEASED [Signature]</p>		<p>66. SIGNATURE OF DECEASED [Signature]</p>	
<p>67. SIGNATURE OF DECEASED [Signature]</p>		<p>68. SIGNATURE OF DECEASED [Signature]</p>	
<p>69. SIGNATURE OF DECEASED [Signature]</p>		<p>70. SIGNATURE OF DECEASED [Signature]</p>	
<p>71. SIGNATURE OF DECEASED [Signature]</p>		<p>72. SIGNATURE OF DECEASED [Signature]</p>	
<p>73. SIGNATURE OF DECEASED [Signature]</p>		<p>74. SIGNATURE OF DECEASED [Signature]</p>	
<p>75. SIGNATURE OF DECEASED [Signature]</p>		<p>76. SIGNATURE OF DECEASED [Signature]</p>	
<p>77. SIGNATURE OF DECEASED [Signature]</p>		<p>78. SIGNATURE OF DECEASED [Signature]</p>	
<p>79. SIGNATURE OF DECEASED [Signature]</p>		<p>80. SIGNATURE OF DECEASED [Signature]</p>	
<p>81. SIGNATURE OF DECEASED [Signature]</p>		<p>82. SIGNATURE OF DECEASED [Signature]</p>	
<p>83. SIGNATURE OF DECEASED [Signature]</p>		<p>84. SIGNATURE OF DECEASED [Signature]</p>	
<p>85. SIGNATURE OF DECEASED [Signature]</p>		<p>86. SIGNATURE OF DECEASED [Signature]</p>	
<p>87. SIGNATURE OF DECEASED [Signature]</p>		<p>88. SIGNATURE OF DECEASED [Signature]</p>	
<p>89. SIGNATURE OF DECEASED [Signature]</p>		<p>90. SIGNATURE OF DECEASED [Signature]</p>	
<p>91. SIGNATURE OF DECEASED [Signature]</p>		<p>92. SIGNATURE OF DECEASED [Signature]</p>	
<p>93. SIGNATURE OF DECEASED [Signature]</p>		<p>94. SIGNATURE OF DECEASED [Signature]</p>	
<p>95. SIGNATURE OF DECEASED [Signature]</p>		<p>96. SIGNATURE OF DECEASED [Signature]</p>	
<p>97. SIGNATURE OF DECEASED [Signature]</p>		<p>98. SIGNATURE OF DECEASED [Signature]</p>	
<p>99. SIGNATURE OF DECEASED [Signature]</p>		<p>100. SIGNATURE OF DECEASED [Signature]</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by filling in by general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6834

CERTIFICATE OF DEATH

06809

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) ROCKS				c. LENGTH OF STAY IN 1b 5 mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROCKS OF DEERCREEK REST HOME				e. STREET ADDRESS RD #1 Box 231 A, BEL AIR			
3. NAME OF DECEASED (Type or print) OSCAR First Middle Last OTIS CLINGENPEEL				4. DATE OF DEATH JUNE 8 19 59 Month Day Year			
5. SEX MALE		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 13, 1899	
9. AGE (In years lost birthday) 59 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIRCRAFT RIVETER				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) MISSOURI				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME CHARLES CLINGENPEEL				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W-I		16. SOCIAL SECURITY NO. 171-05-8298		17. INFORMANT Mrs Lucille R Orlando Address BEL AIR RD 1 Box 231 A Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 ACUTE CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 30 MIN OVER 7 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL VASCULAR ACCIDENT 1952							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from JAN 24, 19 59 to JUNE 8, 19 59 , that I last saw the deceased alive on JUNE 8, 19 59 , and that death occurred at 11:35 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip W. Heuman M.D.				ADDRESS (Street, city or town, state) 307 Hickory BEL AIR, Md			
PHYSICIAN'S NAME (Type) PHILIP W. HEUMAN M.D.				DATE SIGNED JUNE 8, 19 59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 11/59		22c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL GARDENS		22d. LOCATION (City, town, or county) (State) BEL AIR HARFORD Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Foster Bel Air Md				24a. REC'D BY REGISTRAR JUN 10 1959		24b. REGISTRAR'S SIGNATURE William E. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED WHITE, W. J.</p>		<p>2. SEX Male</p>	
<p>3. AGE 50 years</p>		<p>4. RACE White</p>	
<p>5. DATE OF DEATH August 1, 1944</p>		<p>6. PLACE OF DEATH Baltimore, Maryland</p>	
<p>7. TIME OF DEATH 10:30 A.M.</p>		<p>8. CAUSE OF DEATH Coronary Thrombosis</p>	
<p>9. DISEASE OR INJURY Myocardial Infarction</p>		<p>10. MANNER OF DEATH Natural</p>	
<p>11. SIGNATURE OF PHYSICIAN J. Edgar Smith, M.D.</p>		<p>12. SIGNATURE OF REGISTRAR [Signature]</p>	
<p>13. PLACE OF BIRTH Baltimore, Maryland</p>		<p>14. DATE OF BIRTH August 1, 1894</p>	
<p>15. OCCUPATION [Blank]</p>		<p>16. MARITAL STATUS Married</p>	
<p>17. EDUCATION [Blank]</p>		<p>18. RELIGION [Blank]</p>	
<p>19. PREVIOUS ILLNESS [Blank]</p>		<p>20. MEDICAL HISTORY [Blank]</p>	
<p>21. SOCIAL HISTORY [Blank]</p>		<p>22. ADDITIONAL COMMENTS [Blank]</p>	

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THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 100, SECTION 100-101, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 100, SECTION 100-102.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

6818 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
Items 8,9 FilmG244 7-20-59 et

06810

CERTIFICATE OF DEATH

Item 9 FilmG244 6-23-59 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAVRE DE GRACE</u>		LENGTH OF STAY (In this place) <u>30 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAVRE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>127 STOKES ST</u>				STREET ADDRESS (If rural give location) <u>127 STOKES ST</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>HARRY</u> <u>CRESMER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 13, 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JUN 15, 1880</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM E CRESMER</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. TRAGO</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-05-3904</u>		17. INFORMANT & ADDRESS <u>Mrs. MARGARET E CRESMER, MD. HAVRE DE GRACE</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
442X IMMEDIATE CAUSE (A) <u>Cardiac Insufficiency</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio-Renal</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-12-59</u>, 19<u>56</u>, to <u>6-13-59</u>, 19<u>59</u>, that I last saw the deceased alive on <u>6-12-59</u>, 19<u>59</u>, and that death occurred at <u>MD</u>, from the causes and on the date stated above.							
SIGNATURE <u>L. Lewis</u>				ADDRESS (Street, city, town, state) <u>Harford Co. MD</u>			
DATE SIGNED <u>6-15-59</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>6-16-1959</u>		NAME OF CEMETERY OR CREMATORY <u>MT ZION GEN.</u>		LOCATION (City, town, or county) (State) <u>HARFORD CO. MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arline E. Evans</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>Havre de Grace, Md.</u>	
DATE <u>JUN 16 '59</u>							

6835

CERTIFICATE OF DEATH

06811

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood		c. LENGTH OF STAY IN 1b X Edgewood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 40 (rural)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATHERINE Middle DELORES Last CROWE		4. DATE OF DEATH Month JUNE Day 12 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1882
9. AGE (In years last birthday) yrs. 76		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Burke		14. MOTHER'S MAIDEN NAME Barbara Keeley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Regina Frasher, Edgewood, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC AND RENAL DECOMPENSATION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) MANY YEARS		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTROPHIC ARTHRITIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE , 1955, to JUNE 12 , 1959, that I last saw the deceased alive on JUNE 11 , 1959, and that death occurred at 3 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Box 95, Edgewood, MD DATE SIGNED 6/12/59			
ACTUAL SIGNATURE C. W. Stewart, Jr. M.D.		PHYSICIAN'S NAME (Type) C. W. STEWART, JR., M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 15, 1959	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Wilkes Barre, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DATE JUN 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kruel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6836

CERTIFICATE OF DEATH

06812

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY OR TOWN <u>Forest Hill</u>		LENGTH OF STAY (in this place) <u>50 years</u>		CITY OR TOWN <u>Forest Hill</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Abram</u> <u>Gorsuch</u> <u>Ensor</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June</u> <u>30</u> <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>August 14, 1879</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer; Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Ensor</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Gorsuch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-12-4970</u>		17. INFORMANT & ADDRESS <u>Florence W. Ensor Forest Hill, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						450.0 IMMEDIATE CAUSE (A) <u>Hypostatic Lobar Pneumonia</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(B) <u>Generalized Arteriosclerosis</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Parkinson's Disease; Diabetes Mellitus</u>						(C) <u>Generalized Arteriosclerosis</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>June</u> <u>30</u> <u>19 59</u> <u>12:00AM</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> <u>30</u> <u>19 59</u> , to <u>June</u> <u>30</u> <u>19 59</u> , that I last saw the deceased alive on <u>June</u> <u>30</u> <u>19 59</u> , and that death occurred at <u>12:00AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u>				ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u>			
DATE THEREOF <u>7/3/1959</u>				DATE SIGNED <u>July 1, 1959</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Spring</u>		LOCATION (City, town, or county) <u>Forest Hill Maryland</u>		(State)	
24. REC'D BY REGISTRAR <u>JUL 6 '59</u>		REGISTRAR'S SIGNATURE <u>Charles C. Rust</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Rust</u>		ADDRESS <u>Jessettville, Md.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

6819

CERTIFICATE OF DEATH

06813

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de grace</u>				c. LENGTH OF STAY IN 1b <u>16 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Betty</u> Middle <u>C.</u> Last <u>FARNUM</u>				4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>12/10/1891</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Brother</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Canned foods</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James T. Curry</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Pearce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-094941</u>		17. INFORMANT <u>JAMES FARNUM</u> Address <u>Norfolk, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal carcinoma toxic</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>adenocarcinoma, R. Kidney</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 MONTHS</u> <u>14 MONTHS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jun 5</u> , 19 <u>58</u> , to <u>June 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 27</u> , 19 <u>59</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>617 W. Belair Ave</u> DATE SIGNED <u>6-27-59</u> ACTUAL SIGNATURE <u>B. J. Plunkett, Jr.</u> M.D. <u>Abertdeen, Md.</u> PHYSICIAN'S NAME (Type) <u>B. J. Plunkett, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-30-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Freedom Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>New Freedom, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Patterson & Sons</u> ADDRESS <u>Perryville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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071

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06814	
6820										CERTIFICATE OF DEATH	
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace					c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X rural Abingdon				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hugh Middle Fisher Last Fisher					4. DATE OF DEATH Month June Day 7 Year 19 59						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 1883		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer					10b. KIND OF BUSINESS OR INDUSTRY Gen. labor		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Fisher					14. MOTHER'S MAIDEN NAME Miller						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 213-20-2497A		INFORMANT Address Mrs. Mauda Suitt Bel Air, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis, Inferolateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardiovascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 6/6 , 19 59 , to 6/7 , 19 59 , that I lost saw the deceased olive on 6/7 , 19 59 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Box 966 Glenwood, Md 6/9/59 Balto., Md. 7.											
ACTUAL SIGNATURE E. Louis Kahan					M.D. E. Louis Kahan MD						
PHYSICIAN'S NAME (Type) E. Louis Kahan MD											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 6/10/1959		22c. NAME OF CEMETERY OR CREMATORY William Watters			22d. LOCATION (City, town, or county) (State) Coopstown, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Charles C. Kurtz					ADDRESS Jarrettsville Md.		24a. REC'D BY REGISTRAR DATE JUN 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass		

6820

CERTIFICATE OF DEATH

Barford

Barford

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U.S.A.

Illinois

Illinois

Illinois

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1000 1000 1000

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1000 1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6821

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shore de Grace</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>31 Aberdeen</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>				d. STREET ADDRESS <i>1411 Roberts Way</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Harriet A. Salbreath</i>				4. DATE OF DEATH <i>June 29 1959</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/28/74</i>	
9. AGE (In years last birthday) <i>85</i>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>							
13. FATHER'S NAME <i>James Haines</i>				14. MOTHER'S MAIDEN NAME <i>Matilda Lytle</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>307-07-7267</i>			
17. INFORMANT <i>B. A. Byers - son-in-law - same</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Left ventricular failure</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic heart disease</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i> <i>714 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Apr 1</i> , 1958, to <i>June 29</i> , 1959, that I last saw the deceased alive on <i>June 29</i> , 1959, and that death occurred at <i>12 noon</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>B. J. Plunkett, Jr.</i>				DATE SIGNED <i>6-29-59</i>			
PHYSICIAN'S NAME (Type) <i>B. J. Plunkett Jr.</i>				ADDRESS (Street, city or town, state) <i>617 W. Belair Ave. Aberdeen, Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>6/30/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Elm Ridge</i>		22d. LOCATION (City, town, or county) (State) <i>Muncie, Indiana</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John E. Tarring</i>				24a. REC'D BY REGISTRAR DATE <i>JUL 6 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1900</i></p>		<p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p>	
<p>6. OCCUPATION <i>Teacher</i></p>		<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 10 1925</i></p>		<p>9. NAME OF SPOUSE <i>Jane Doe</i></p>		<p>10. PLACE OF MARRIAGE <i>Baltimore, Md.</i></p>	
<p>11. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>12. PLACE OF DEATH <i>Home</i></p>		<p>13. DATE OF DEATH <i>Dec 10 1945</i></p>		<p>14. TIME OF DEATH <i>10:30 AM</i></p>		<p>15. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>16. SIGNATURE OF WITNESS <i>Jane Doe</i></p>		<p>17. SIGNATURE OF PHYSICIAN <i>Dr. Smith</i></p>		<p>18. SIGNATURE OF CLERK <i>John Doe</i></p>		<p>19. SIGNATURE OF JURY <i>John Doe</i></p>		<p>20. SIGNATURE OF JURY <i>John Doe</i></p>	

1. This certificate is to be filled out by the physician or the person who attended the deceased at the time of death. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland.

2. The certificate is to be filled out in duplicate. One copy is to be retained in the office of the Registrar, and the other copy is to be sent to the office of the County Health Officer.

3. The certificate is to be filled out in duplicate. One copy is to be retained in the office of the Registrar, and the other copy is to be sent to the office of the County Health Officer.

4. The certificate is to be filled out in duplicate. One copy is to be retained in the office of the Registrar, and the other copy is to be sent to the office of the County Health Officer.

5. The certificate is to be filled out in duplicate. One copy is to be retained in the office of the Registrar, and the other copy is to be sent to the office of the County Health Officer.

6. The certificate is to be filled out in duplicate. One copy is to be retained in the office of the Registrar, and the other copy is to be sent to the office of the County Health Officer.

7. The certificate is to be filled out in duplicate. One copy is to be retained in the office of the Registrar, and the other copy is to be sent to the office of the County Health Officer.

8. The certificate is to be filled out in duplicate. One copy is to be retained in the office of the Registrar, and the other copy is to be sent to the office of the County Health Officer.

9. The certificate is to be filled out in duplicate. One copy is to be retained in the office of the Registrar, and the other copy is to be sent to the office of the County Health Officer.

10. The certificate is to be filled out in duplicate. One copy is to be retained in the office of the Registrar, and the other copy is to be sent to the office of the County Health Officer.

6837

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dublin				c. LENGTH OF STAY IN 1b 52 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Darlington R.D.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RALPH Middle COAST Last GALLION				4. DATE OF DEATH Month June Day 7 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 12, 1906	
9. AGE (In years last birthday) 52 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proof technician		10b. KIND OF BUSINESS OR INDUSTRY Civil service		11. BIRTHPLACE (State or foreign country) Dublin, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George K. Gallion		14. MOTHER'S MAIDEN NAME Sadie Burkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-20-7692		17. INFORMANT Mrs. Anna Mae Gallion, Dublin, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 1 mmcd	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 8, 1947 , to June 7, 1959 , that I last saw the deceased alive on June 7, 1959 , and that death occurred at 11 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Darlington Md DATE SIGNED 6/8/59							
ACTUAL SIGNATURE Dudley Phillipino M.D.				PHYSICIAN'S NAME (Type) Darlington Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 10, 1959		22c. NAME OF CEMETERY OR CREMATORY Southern		22d. LOCATION (City, town, or county) (State) Dublin, Harford Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harbins				24a. REC'D BY REGISTRAR Delta, Penna.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35 years		4. RACE White	
5. DATE OF DEATH April 4, 1968		6. TIME OF DEATH 1:00 PM		7. PLACE OF DEATH Memphis, Tennessee		8. COUNTY Shelby	
9. CITY Memphis		10. STATE Tennessee		11. ZIP CODE 38101		12. MARRIAGE STATUS Single	
13. OCCUPATION Attorney		14. EDUCATION High School Graduate		15. RELIGION Methodist		16. MARITAL STATUS Single	
17. CAUSE OF DEATH Gunshot wound		18. MANNER OF DEATH Homicide		19. PLACE OF BIRTH Alton, Illinois		20. DATE OF BIRTH January 19, 1933	
21. SIGNATURE OF DECEASED (Signature)		22. SIGNATURE OF WITNESS (Signature)		23. SIGNATURE OF PHYSICIAN (Signature)		24. SIGNATURE OF CORONER (Signature)	
25. SIGNATURE OF JUDGE (Signature)		26. SIGNATURE OF CLERK (Signature)		27. SIGNATURE OF REGISTRAR (Signature)		28. SIGNATURE OF NOTARY (Signature)	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06817

6822

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bel Air</u>		LENGTH OF STAY (in this place) <u>2 Mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Edgewood</u>		STREET ADDRESS (If rural give location) <u>Willoughby Beach</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Conv. Home</u>							
3. NAME OF DECEASED (Type or Print) <u>Ellen S. Goodrich</u>				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>15</u> (Year) <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widow</u>		8. DATE OF BIRTH <u>March 23, 1879</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Practical Nurse</u>		9. AGE last birthday <u>80</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Madary</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT & ADDRESS <u>Eggedwood, Md.</u> <u>Mrs. Emory Goodrich, Willoughby Beach,</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
157X IMMEDIATE CAUSE (A) <u>Carcinoma of the Pancreas</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 30</u>, 19<u>59</u>, to <u>June 15</u>, 19<u>59</u>, that I last saw the deceased alive on <u>June 14</u>, 19<u>59</u>, and that death occurred at <u>1:05 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Winward P. Hudson</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u>			
DATE <u>JUN 22 '59</u>				DATE SIGNED <u>June 16, 1959</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 18, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Porspect Hill</u>		LOCATION (City, town, or county) (State) <u>Towson, Balto., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard L. Morris</u> ADDRESS <u>Abingdon Td</u>			

CERTIFICATE OF DEATH

Page No. 18

1. DECEASED'S NAME (Last, first, middle)

2. PLACE OF DEATH

3. SEX (Male or Female)

4. RACE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. MARITAL STATUS

9. PRESENT ADDRESS

10. DATE OF DEATH

11. CAUSE OF DEATH

12. MEDICAL HISTORY

13. PREVIOUS ILLNESS

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF DECEASED

18. SIGNATURE OF NEAREST RELATIVE

19. SIGNATURE OF CLERGYMAN

20. SIGNATURE OF BURIAL OFFICIAL

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF ASSISTANT

23. SIGNATURE OF CLERK

24. SIGNATURE OF CHIEF

25. SIGNATURE OF DEPUTY

26. SIGNATURE OF ASSISTANT

27. SIGNATURE OF CLERK

28. SIGNATURE OF CHIEF

29. SIGNATURE OF DEPUTY

30. SIGNATURE OF ASSISTANT

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167. SIGNATURE OF CLERK

168. SIGNATURE OF CHIEF

169. SIGNATURE OF DEPUTY

170. SIGNATURE OF ASSISTANT

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6838

CERTIFICATE OF DEATH

06818

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARDIFF				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARDIFF			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) PEARL M. HEAPS				4. DATE OF DEATH Month JUNE Day 28 Year 1959			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-24-1882	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) HARFORD CO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK HEAPS				14. MOTHER'S MAIDEN NAME NELLIE FURLOUGH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs John Hushon Cardiff, Wid.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 DUE TO chronic disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cardiomyopathy of the liver (c) cardiomyopathy of the liver				INTERVAL BETWEEN ONSET AND DEATH 20 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 27, 1959 , to June 28, 1959 , that I last saw the deceased alive on June 27, 1959 , and that death occurred at 125 A M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED 6/29/59			
ACTUAL SIGNATURE BENJAMIN DOROB M.D.							
PHYSICIAN'S NAME (Type) BENJAMIN DOROB				CARDIFF, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-1-59		22c. NAME OF CEMETERY OR CREMATORY ST. MARYS		22d. LOCATION (City, town, or county) (State) PLYESVILLE, HARFORD CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. Crum				ADDRESS Stewartstown, Pa		24a. REC'D BY REGISTRAR JUN 30 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraw			

CERTIFICATE OF DEATH

1933

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESS		12. SIGNATURE OF PHYSICIAN	
JAMES H. HARRIS		Male		45		1888		Baltimore, Md.		Carpenter		Heart Disease		Home		10:30 AM		J. H. Harris		J. H. Harris		J. H. Harris	
13. PLACE OF INTERMENT		14. NAME OF INTERMENT		15. DATE OF INTERMENT		16. NAME OF MINISTER		17. NAME OF CHURCH		18. NAME OF FUNERAL HOME		19. NAME OF CEMETERY		20. NAME OF BURIAL		21. NAME OF CREMATION		22. NAME OF INCINERATION		23. NAME OF URN		24. NAME OF CASK	
St. Paul's Episcopal Church		St. Paul's Episcopal Church		1933		J. H. Harris		St. Paul's Episcopal Church		J. H. Harris		St. Paul's Episcopal Church		St. Paul's Episcopal Church		St. Paul's Episcopal Church		St. Paul's Episcopal Church		St. Paul's Episcopal Church		St. Paul's Episcopal Church	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6823

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06819

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE	c. LENGTH OF STAY IN TB 2 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 HAURE DE GRACE	
d. NAME OF HOSPITAL (If not in hospital, give street address) HARFORD MEMORIAL HOSP.		d. STREET ADDRESS 223 Bloomsbury Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First BABY Middle JOY Last KEECH		4. DATE OF DEATH Month JUNE Day 5 Year 19 59	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-3-59
9. AGE (In years lost birthday) yrs. 2		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min. 2	IF UNDER 24 HRS. Months 2 Days 2 Hours 2 Min. 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert Eugene KEECH	
14. MOTHER'S MARRIED NAME GENEVA DEAN Ackinson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neonatal atelectasis 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md DATE SIGNED 6/6/59			
ACTUAL SIGNATURE Neil Taylor M.D.		PHYSICIAN'S NAME (Type)	
22a. DATE OF CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6-6-59	
22c. NAME OF CEMETERY OR CREMATORY HARFORD MEMORIAL HOSPITAL		22d. LOCATION (City, town, or county) (State) Haure de Grace, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Harry R. Zully administrator		24a. REC'D BY REGISTRAR DATE JUN 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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CERTIFICATE OF DEATH

06820

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>27 x 2</u>	
3. NAME OF DECEASED (Type or print) <u>Charles M. Keesey</u>		4. DATE OF DEATH <u>June 3, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 10, 1907</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Taxi-cab owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Keesey</u>		14. MOTHER'S MAIDEN NAME <u>Frances Ward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>338-10-4337</u>	
17. INFORMANT <u>Edward Jeff (nephew)</u>		Address <u>Perryville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary-arterio-Sclerosis</u> (c) <u>420.1</u> DUE TO <u>Coronary-arterio-Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1959</u> to <u>June 3, 1959</u> that I last saw the deceased alive on <u>June 3, 1959</u> and that death occurred at <u>1:30 p.m.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Harttsport, Md</u> DATE SIGNED <u>June 7, 1959</u>	
ACTUAL SIGNATURE <u>Clarence I. Benson</u>		PHYSICIAN'S NAME (Type) <u>Dr. Clarence I. Benson</u>	
22a. BURIAL, CREMATION, REMOVAL (specify) <u>Burial</u>		22b. DATE THEREOF <u>6-6-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Marks Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Perryville, Md. Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leva Peterson & Sons</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

6839

CERTIFICATE OF DEATH

06821

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Fallston		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Fallston	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Joseph Last Kennedy		4. DATE OF DEATH Month June Day 1 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1876
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Rutledge, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Kennedy		14. MOTHER'S MAIDEN NAME Catherine Norman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Mrs. Robert Wagner Fallston, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac disease DUE TO (b) Coronary Stomach DUE TO (c) 2 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 30, 1959 to June 1, 1959 , that I last saw the deceased alive on May 30, 1959 , and that death occurred at 6 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter M. Hammond		DATE SIGNED June 1, 1959	
PHYSICIAN'S NAME (Type) Walter M. Hammond		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/3/1959	22c. NAME OF CEMETERY OR CREMATORY St. Johns	22d. LOCATION (City, town, or county) (State) Hydes Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurtz		24a. REC'D BY REGISTRAR June 3 '59	
ADDRESS Jarrettsville, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and compared with the original, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00881

CERTIFICATE OF DEATH

8238

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

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Married

Married

Married

Married

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
Item 2, Film G244. 6/19/59 fcy

06823

6844

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR RURAL</u>		LENGTH OF STAY (in this place) <u>4 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR RURAL</u>		TOWN <u>Forest Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WALKER'S CONVALESCENT HOME</u>				STREET ADDRESS (If rural give location) <u>WALKER'S CONVALESCENT HOME</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LOTTIE</u>		(Middle) <u>LACKEY</u>		(Last) <u>LACKEY</u>		(Month) (Day) (Year) <u>JUNE 11, 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JUNE 21, 1876</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEKEEPER</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY LACKEY</u>				14. MOTHER'S MAIDEN NAME <u>MARY JANE BUNCE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT & ADDRESS <u>Walter's Convalescent Home Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr. cardio-vascular disease</u>						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 1949</u> , to <u>June 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>59</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wiliard P. Hudson</u>				ADDRESS (Street, city, town, state) <u>M.D. Forest Hill Maryland</u>		DATE SIGNED <u>6-12-59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>JUNE 14, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Spring Church Cemetery</u>		LOCATION (City, town, or county) (State) <u>Forest Hill, Harford Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>		ADDRESS <u>W. Broadway & Williams St. BEL AIR, Maryland</u>	
DATE <u>JUN 15 '59</u>							

CERTIFICATE OF DEATH

Form 10-1-36

1. NAME OF DECEASED

John J. Smith

2. SEX

Male

3. AGE

45

4. RACE

White

5. BIRTH DATE

12-15-1890

6. PLACE OF BIRTH

St. Louis, Mo.

7. PRESENT RESIDENCE

1234 N. Main St., Baltimore, Md.

8. DATE OF DEATH

11-15-1941

9. TIME OF DEATH

10:30 AM

10. CAUSE OF DEATH

Heart Disease

11. SEX

Male

12. AGE

45

13. RACE

White

14. BIRTH DATE

12-15-1890

15. PLACE OF BIRTH

St. Louis, Mo.

16. PRESENT RESIDENCE

1234 N. Main St., Baltimore, Md.

17. DATE OF DEATH

11-15-1941

18. TIME OF DEATH

10:30 AM

19. CAUSE OF DEATH

Heart Disease

20. SIGNATURE OF PHYSICIAN

John J. Smith, M.D.

21. SIGNATURE OF REGISTRAR

John J. Smith, Registrar

22. SIGNATURE OF WITNESS

John J. Smith, Witness

23. SIGNATURE OF DECEASED

John J. Smith, Deceased

24. SIGNATURE OF NEAREST RELATIVE

John J. Smith, Relative

25. SIGNATURE OF CLERK

John J. Smith, Clerk

26. SIGNATURE OF JUDGE

John J. Smith, Judge

27. SIGNATURE OF SHERIFF

John J. Smith, Sheriff

28. SIGNATURE OF CORONER

John J. Smith, Coroner

29. SIGNATURE OF JURY

John J. Smith, Jury

30. SIGNATURE OF COURT

John J. Smith, Court

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

6825

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06824

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>#</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Bluff</u> 83X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dea Hartford Memorial Hosp, Md</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Samuel David</u> First Middle Last		4. DATE OF DEATH <u>June 10</u> 19 <u>59</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-11-32</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory Auto</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Virgil R. Dawson</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Blackwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>Korea</u>		16. SOCIAL SECURITY NO. <u>232-52-8002</u>	
17. INFORMANT <u>Father: Cedar Bluff, Va. Box 12 A. R. 9. #1.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound fracture skull</u> 823 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - car went out of control and smashed against a fence</u>	
20c. TIME OF INJURY Month, Day, Year <u>6-10-59</u> Hour <u>2</u> a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Perryman Road</u>		20f. (City or town) <u>nr. Perryman</u> (County) <u>Harford</u> (State) <u>Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Ronald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>Bell Air, Md</u> DATE SIGNED <u>6-10-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6/12/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mountain View</u>		22d. LOCATION (City, town, or county) <u>Abingdon</u> (State) <u>Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Barrag</u> ADDRESS <u>Abingdon, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 15 1959</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1937

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various fields.]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06825

6840

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		STATE <u>Md</u> COUNTY <u>HARFORD</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
TOWN <u>Joppa</u>		LENGTH OF STAY (in this place) <u>14 YRS</u>		TOWN <u>Joppa</u>		STREET ADDRESS (If rural give location) <u>RT #1 NEAR MT. Rd.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RT #1 NEAR MT. Rd.</u>				STREET ADDRESS <u>RT #1 NEAR MT. Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>SARAH</u> (First) <u>MARBURG</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>JUNE</u> (Day) <u>2</u> (Year) <u>19</u> <u>59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>FEB 28,</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES WOMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ABRAHAM MARBURG</u>				14. MOTHER'S MAIDEN NAME <u>MARY BRUSH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>WINNIE MARBURG - SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>ACUTE CORONARY THROMBOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>HYPERTENSION WITH</u>				OVER 5 YRS			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>CARDIAC INSUFFICIENCY</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>FEB</u> , 19 <u>57</u> , to <u>JUNE 2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MAY 4</u> , 19 <u>57</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Philip W. Heurman</u> M.D. <u>307 HICKORY</u>				DATE SIGNED <u>BEL AIR, MD JUNE 2, 59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-4-59</u>		NAME OF CEMETERY OR CREMATORY <u>United Hebrew</u>		LOCATION (City, town, or county) (State) <u>Balto, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jaen Lewis</u> ADDRESS <u>2100 Canton Pl</u>			
DATE <u>JUN 3 '59</u>							

to improve the

6826

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06826

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De Grace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) York	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dr's Office		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Martin Last Mc Clune		4. DATE OF DEATH Month June Day 28 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1900
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John T. Mc Clune		14. MOTHER'S MAIDEN NAME May L. Owens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 175-10-6964	
17. INFORMANT Hester R. Mc Clune		Address 57 Franklin St. York, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease ? (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 day			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from June 28th, 1959 to June 28, 1959 that I lost saw the deceased alive on June 28th, 1959 , and that death occurred at 6 p. m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edw. C. Loo, MD		ADDRESS (Street, city or town, state) 211 N. Union Ave. Havre de Grace, Ind.	
DATE SIGNED 6/29/59		DATE SIGNED 6/29/59	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 6-7-2-1959	
22c. NAME OF CEMETERY OR CREMATORY Mount Rose Cemetery		22d. LOCATION (City, town, or county) (State) York, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Leea. Patterson & Sons		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR JUL 1 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hunt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Corner of Harford County Dr. J. Palmer has been notified.

CERTIFICATE OF DEATH

Married

John T. McGee

John T. McGee

George

White

Married

John T. McGee

John T. McGee

197-10-8981, McGee & McGee, 1000 10th St.

John T. McGee

John T. McGee

John T. McGee

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6841

CERTIFICATE OF DEATH

06827

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magnolia</u>				c. LENGTH OF STAY IN 1b <u>lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Carrie E. Mc Kinney</u>				4. DATE OF DEATH Month <u>June</u> , Day <u>30</u> , Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 13, 1888</u>	9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Magnolia, Md.,</u>	
13. FATHER'S NAME <u>Benjamin Bowen</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mosby Mc Kinney</u> Address <u>Magnolia Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE ARTERIOSCLEROTIC</u> DUE TO (c) <u>CARDIOVASCULAR DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>MANY</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>DEC 15/52</u> , 19 <u>52</u> , to <u>6/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/29</u> , 19 <u>59</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. W. Stewart Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Box 95</u> DATE SIGNED <u>7/2/59</u>			
PHYSICIAN'S NAME (Type) <u>C. W. STEWART, JR., M.D.</u>				<u>EDGEWOOD, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July, 3, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard McCombs Jr</u>				ADDRESS <u>Abingdon, Maryland.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 7 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
Benjamin Brown		June 13, 1953	
SEX		RACE	
Male	White	White	
AGE		DATE OF BIRTH	
45	June 13, 1908	June 13, 1908	
PLACE OF BIRTH		CITY OF BIRTH	
Maryland		Baltimore	
MARRIAGE		OCCUPATION	
Married	None	None	
NAME OF MOTHER		NAME OF FATHER	
Maryland		Maryland	
CAUSE OF DEATH			
CORONARY OCCLUSION			
INTERESTING HISTORICAL			
CARDIOVASCULAR DISEASE			
—			
—			
A.M. 6/13/53			
22			
M.D.			
SIGNATURE OF PHYSICIAN		DATE	
Benjamin Brown		June 13, 1953	
SIGNATURE OF REGISTRAR		DATE	
Benjamin Brown		June 13, 1953	

6822 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

06828

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harre-de-Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>1353 Lafayette ST</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>G. Nelson</u> First Middle Last		4. DATE OF DEATH Month <u>6</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 3, 1912</u>
9. AGE (In years lost birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HAULING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORAGE & MOVING</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE N. MITCHELL SR.</u>		14. MOTHER'S MAIDEN NAME <u>SARAH EVELYN JACKSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. LENA J. MITCHELL - HARRE DE GRACE MD.</u>		Address <u>353 LAFAYETTE ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 14, 1959</u> to <u>June 13, 1959</u> , that I lost saw the deceased alive on <u>June 13, 1959</u> , and that death occurred of <u>—</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. L. Lewis MD</u>		ADDRESS (Street, city or town, state) <u>Harre de Grace MD</u> DATE SIGNED <u>6/19</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-17-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>HARRE DE GRACE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>Harre de Grace, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6842

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Aberdeen		c. LENGTH OF STAY IN 1b Rural, Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #3		d. STREET ADDRESS R.D. #3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		4. DATE OF DEATH Month June Day 29 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept., 3, 1861
9. AGE (In years last birthday) yrs. 97		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Thomas Carroll		14. MOTHER'S MAIDEN NAME Mary Allen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ** **	
17. INFORMANT Mrs. R. Leslie Hughes		Address R.D. #3 Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 week 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-3 , 19 57 , to 6-29 , 19 59 , that I last saw the deceased alive on 6-29 , 19 59 , and that death occurred at 12:20pm from the causes and on the date stated above.			
ACTUAL SIGNATURE B.J. Plunkett Jr.		ADDRESS (Street, city or town, state) DATE SIGNED 617 W. Bel Air Ave.	
PHYSICIAN'S NAME (Type) B.J. Plunkett Jr. M.D.		Aberdeen, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/2/59	22c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery	22d. LOCATION (City, town, or county) (State) Perryman, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John Y. Tarrington		24a. REC'D BY REGISTRAR JUL 6 '59	
ADDRESS Aberdeen, Md.		24b. REGISTRAR'S SIGNATURE William S. Krawtchuk	

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6828

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film 3244 7-1-59 et

06830

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrode Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harrode Grace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>N. Stokes St</u>		d. STREET ADDRESS <u>637 N. Stokes St</u>	
3. NAME OF DECEASED (Type or print) <u>Edna Etta Pierce</u>		4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/31/1923</u>
9. AGE (In years, months, and days) <u>35</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. BIRTHPLACE (State or foreign country) <u>Harrode Grace, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Moulton</u>		14. MOTHER'S MAIDEN NAME <u>Paul Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Lat M. Prince</u>		18. ADDRESS <u>637 N. Stokes Harrode Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to strangulation</u> 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanged self = lamp cord</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> a.m. <u>6-25-59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Harrode Grace Harford MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lester C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerold C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6/28/59 Angel Hill</u>		22b. DATE THEREOF <u>6/28/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Harrode Grace, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Harrode Grace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carroll M. Palmer</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 30 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

6829

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Hanford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Hanford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanover-de-Grace</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hanford Memorial Hospital</i>				e. STREET ADDRESS <i>R D # 1</i>			
3. NAME OF DECEASED (Type or print) <i>William Russell Schofield</i>				4. DATE OF DEATH Month <i>6</i> Day <i>6</i> Year <i>1959</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>7/10/1891</i>	9. AGE (In years last birthday) <i>67</i> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Isaac Henry Schofield</i>				14. MOTHER'S MAIDEN NAME <i>Carrie Schofield (Russell)</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-10-3804</i>		17. INFORMANT <i>William Schofield</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>540.1 Perforated gastric ulcer</i> DUE TO <i>Gastric Ulcer</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>2 hr.</i> (c) <i>2 mo.</i>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of liver, metastatic</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6-6-59</i> , 19 <i>59</i> , to <i>6-6-59</i> , that I last saw the deceased alive on <i>6-6-59</i> , 19 <i>59</i> , and that death occurred at <i>6-8-59</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Peter P. Rodman</i>				ADDRESS (Street, city or town, state) <i>8 Law St. Aberdeen, Md.</i> DATE SIGNED <i>6-8-59</i>			
PHYSICIAN'S NAME (Type) <i>Peter P. Rodman</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/10/1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Sheshta Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Perryman, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Sarnig</i> ADDRESS <i>Aberdeen, Maryland</i>				24a. REC'D BY REGISTRAR <i>John G. Sarnig</i>		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6830 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY OR TOWN <u>Bel Air</u>		LENGTH OF STAY (in this place) <u>2 months</u>		CITY OR TOWN <u>Port Deposit</u>		07X-2 ✓	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescent Home</u>				STREET ADDRESS (if rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Elizabeth Smithson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 8 19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Single</u>	8. DATE OF BIRTH <u>June 8, 1864</u>	9. AGE last birthday <u>98</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Natron</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>College</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathaniel Smithson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Grace C. Tome</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						3 days	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion,</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Chr. Cardio-vascular disease</u>						?	
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>April 12, 1959</u> , to <u>June 8, 1959</u> , that I last saw the deceased alive on <u>June 8, 1959</u> , and that death occurred at <u>10:00P</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>June 9, 1959</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-12-1959</u>		NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem.</u>		LOCATION (City, town, or county) (State) <u>Colora, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wesley Patterson</u>		ADDRESS <u>Perryville, Md.</u>	
DATE <u>JUN 12 '59</u>							

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DEATH CERTIFICATE

<p>1. DECEASED</p> <p>NAME: <u>John Doe</u></p> <p>DATE OF BIRTH: <u>1900-01-01</u></p> <p>PLACE OF BIRTH: <u>John Doe</u></p> <p>DATE OF DEATH: <u>1950-01-01</u></p> <p>PLACE OF DEATH: <u>John Doe</u></p>		<p>2. CAUSE OF DEATH</p> <p>IMMEDIATE CAUSE: <u>John Doe</u></p> <p>UNDERLYING CAUSE: <u>John Doe</u></p> <p>INTERMEDIATE CAUSE: <u>John Doe</u></p> <p>OTHER CAUSE: <u>John Doe</u></p>	
<p>3. MEDICAL HISTORY</p> <p>PREVIOUS ILLNESS: <u>John Doe</u></p> <p>PREVIOUS SURGERY: <u>John Doe</u></p> <p>PREVIOUS TRAUMA: <u>John Doe</u></p> <p>PREVIOUS DRUGS: <u>John Doe</u></p>		<p>4. MEDICAL CERTIFICATION</p> <p>DATE OF CERTIFICATION: <u>John Doe</u></p> <p>PLACE OF CERTIFICATION: <u>John Doe</u></p> <p>CERTIFYING PHYSICIAN: <u>John Doe</u></p>	
<p>5. OTHER INFORMATION</p> <p>DATE OF BIRTH: <u>John Doe</u></p> <p>PLACE OF BIRTH: <u>John Doe</u></p> <p>DATE OF DEATH: <u>John Doe</u></p> <p>PLACE OF DEATH: <u>John Doe</u></p>		<p>6. SIGNATURE</p> <p>DATE: <u>John Doe</u></p> <p>PLACE: <u>John Doe</u></p> <p>SIGNATURE: <u>John Doe</u></p>	

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST.

6831

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X HAVRE DE GRACE</u>			
c. LENGTH OF STAY IN 1b <u>9 res.</u>				d. STREET ADDRESS <u>RD. 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LEONA S.</u> First Middle Last				4. DATE OF DEATH <u>JUNE 13</u> Month Day Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 1, 1874</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				13. FATHER'S NAME <u>UNK.</u>			
14. MOTHER'S MAIDEN NAME <u>UNK.</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Mrs. Willard ANDERSON</u> Address <u>HAVRE DE GRACE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>570.2</u> DUE TO <u>Infarction of intestine due to</u> <u>mesenteric thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 13</u> , 19 <u>59</u> , to <u>June 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 13</u> , 19 <u>59</u> , and that death occurred at <u>8:15</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-15-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCKYON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HARFORD CO., MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>HAVRE DE GRACE, MD</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH City or Town		2. FULL RESIDENCE of deceased at date of death	
3. DATE OF DEATH		4. TIME OF DEATH	
5. PLACE OF BIRTH		6. DATE OF BIRTH	
7. SEX		8. RACE	
9. MARRIED		10. SINGLE	
11. OCCUPATION		12. CAUSE OF DEATH	
13. MEDICAL HISTORY		14. PRESENT ILLNESS	
15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF REGISTRAR	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESSES	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESSES	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESSES	
23. SIGNATURE OF DECEASED		24. SIGNATURE OF WITNESSES	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF WITNESSES	
27. SIGNATURE OF DECEASED		28. SIGNATURE OF WITNESSES	
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41. SIGNATURE OF DECEASED		42. SIGNATURE OF WITNESSES	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF WITNESSES	
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51. SIGNATURE OF DECEASED		52. SIGNATURE OF WITNESSES	
53. SIGNATURE OF DECEASED		54. SIGNATURE OF WITNESSES	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF WITNESSES	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF WITNESSES	
59. SIGNATURE OF DECEASED		60. SIGNATURE OF WITNESSES	
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71. SIGNATURE OF DECEASED		72. SIGNATURE OF WITNESSES	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF WITNESSES	
75. SIGNATURE OF DECEASED		76. SIGNATURE OF WITNESSES	
77. SIGNATURE OF DECEASED		78. SIGNATURE OF WITNESSES	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF WITNESSES	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF WITNESSES	
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91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESSES	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF WITNESSES	
95. SIGNATURE OF DECEASED		96. SIGNATURE OF WITNESSES	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF WITNESSES	
99. SIGNATURE OF DECEASED		100. SIGNATURE OF WITNESSES	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06834

6843

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR Rural</u>		LENGTH OF STAY (In this place) <u>10 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>FOREST HILL</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARTFORD CO HOME</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>Grey</u> <u>W</u> <u>Tyson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 23</u> <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>FEB 17 - 1892</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Churchville MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>James W Tyson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>✓</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>Alfred S Tyson</u> <u>4008 1/2 St Bel Air MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
4221 IMMEDIATE CAUSE (A) <u>Anterior wall MI disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-1</u>, 19 <u>59</u>, to <u>JUNE 23</u>, 19 <u>59</u>, that I last saw the deceased alive on <u>JUNE 21</u>, 19 <u>59</u>, and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Gerald C Palmer</u> M.D.				ADDRESS (Street, city, town, state) <u>Bel Air Md.</u>		DATE SIGNED <u>6-23-59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JUNE 25/59</u>		NAME OF CEMETERY OR CREMATORY <u>Angels Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>HARTFORD CO HARTFORD MD</u>	
24. REC'D BY REGISTRAR <u>UN 29 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur E. Kinsler</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Fato</u>		ADDRESS <u>Bel Air Md</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The death certificate has been signed by the attending physician and completed by the registrar. Pages 1 and 2 should be filled with the information required for the burial-transit permit. Then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06835

6832

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hawthorn Grace 1/2 hour</u>		c. LENGTH OF STAY (IN 1b) <u>24</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Clouglar</u> Middle <u>Hoffkill</u> Last <u>June</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1939</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (In years last birthday) yrs. <u>39</u>
11. BIRTHPLACE (State or foreign country) <u>Harford Co., MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Hoffkill</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Sexton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>David Hoffkill, Gray, Thorn</u>		Address <u>114 300</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGENITAL HEART DEFORMITY</u> <u>754.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <u>6:20.59</u> , 19 <u>59</u> , to <u>6:20.59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6:20.59</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>RBN</u> M.D.			
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>June 21, 1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Harlington</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co., MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H & Bailey</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 25 '59</u>	
ADDRESS _____		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

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